The JOURNAL *of the Oklahoma State Medical Association*

Volume 49 **JANUARY, 1956** Number 1

CONTENTS

EDITORIALS

1 The Mean, the Median and the Mode

1 Social Security—Big Issue in '56

SCIENTIFIC ARTICLES

3 Anatomic and Functional Alterations of the Carpus Following Injury and Excision, *James K. Stack, M.D., F.A.C.S.*

6 Indications, Technique and Aftercare of Tracheotomy, *Robert M. Shepard, Jr., M.D.*

10 Abridged Oklahoma Life Tables, 1949-1951, *John C. Belcher, Ph.D., and James D. Tarver, Ph.D.*

ASSOCIATIONAL ACTIVITIES

18 Have You Heard?

20 President's Letter

22 Academy of General Practice Issues Invitation To Meeting

22 Announcements

22 Bondurant Named Chairman of Public Welfare Group

26 Deaths

28 Physician Placement

30 Report on Actions of the House of Delegates, American Medical Association 9th Clinical Meeting

Classified Advertising, xviii

THE JOURNAL is the official publication of the Oklahoma State Medical Association, and is published monthly except semi-monthly in April, under the direction of the Council, 1227 Classen Drive, Oklahoma City 3, Oklahoma. Publication office (printer): 111 South Peters Avenue, Norman, Oklahoma. Send all change of address notices to 1227 Classen Drive, Oklahoma City 3, Oklahoma.

Entered as second-class mail at the post office at Norman, Oklahoma, under the Act of Congress of March 3, 1879. Copyright, 1955, by the Oklahoma State Medical Association.

EDITORIAL BOARD

Ben H. Nicholson, M.D., Oklahoma City, Editor-in-Chief; **E. Eugene Rice, M.D.,** Shawnee; **John G. Matt, M.D.,** Tulsa; **Mary Lou Crahan,** Editorial Assistant; **Dick Graham,** Oklahoma City, Business Manager, **Don Blair,** Oklahoma City, Associate Business Manager.

CONTRIBUTIONS

Articles accepted by this Journal for publication including those read at the annual meetings of the State Association are the sole property of this Journal.

The Editorial Department is not responsible for the opinions expressed in the original articles of contributors.

MANUSCRIPTS

Manuscripts may be withdrawn by authors for publication elsewhere only upon the approval of the Editorial Board.

Manuscripts should be typewritten, double-spaced, on white paper 8½ x 11 inches. The original copy and one carbon copy should be submitted.

Footnotes, bibliographies and legends for illustrations should be typed on separate sheets in double space. Bibliography listings should follow this order: Name of author, title of article, name of periodical with volume, page and date of publication.

Manuscripts are accepted subject to the usual editorial revisions and with the understanding that they have not been published elsewhere.

NEWS

Local news of interest to the medical profession, changes of address, births, deaths and weddings will be gratefully received.

ADVERTISING

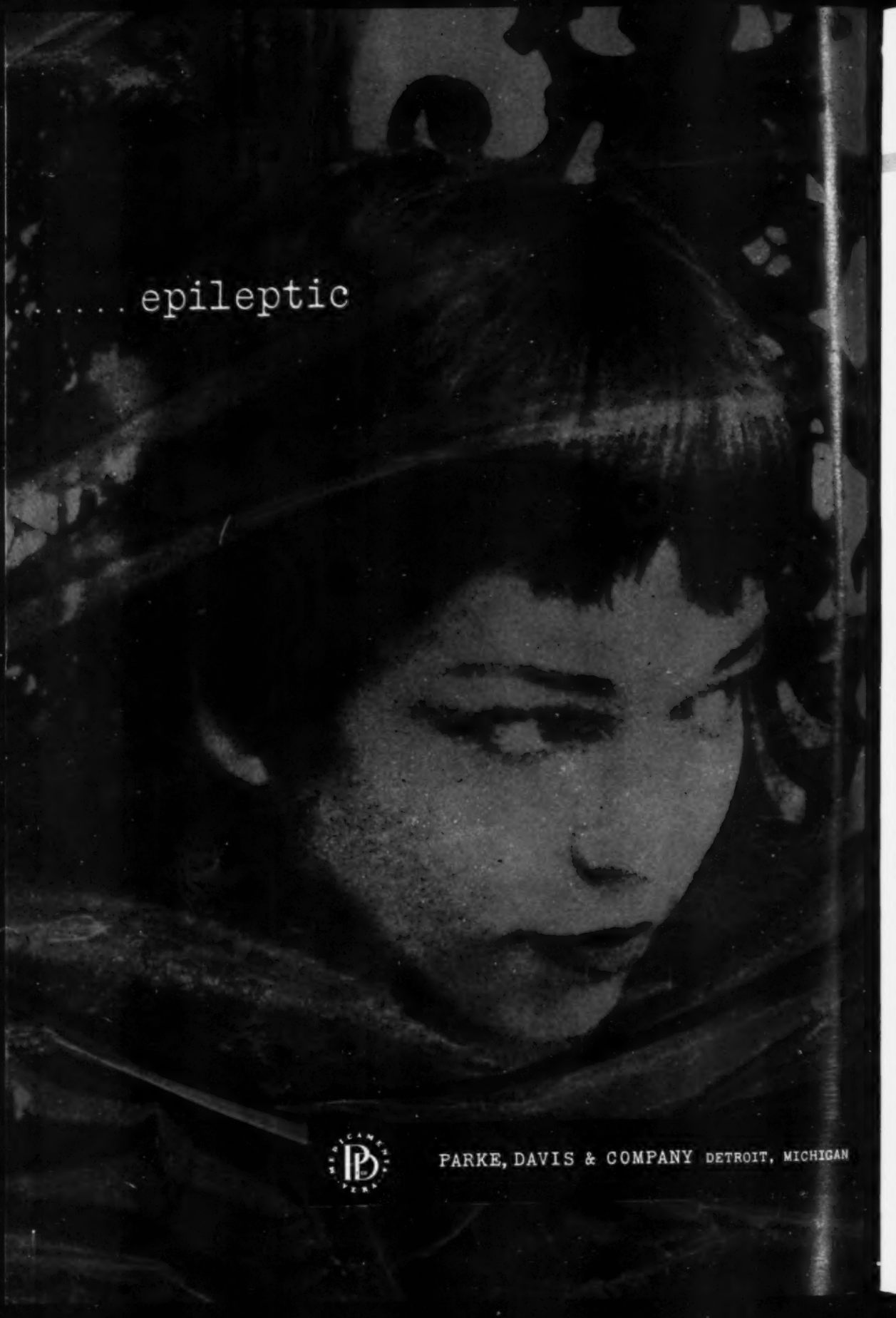
Advertising of articles, drugs or compounds unapproved by the Council on Pharmacy of the A.M.A. will not be accepted. Advertising rates will be supplied on application. It is suggested that members of the State Association patronize our advertisers in preference to others.

SUBSCRIPTIONS

Subscription to *The Journal* is included in membership fee. Other subscriptions are $5.50 per year or $1.00 per copy with each request subject to approval of the Editorial Board.

REPRINTS

Reprints of original articles will be supplied at actual cost provided request for them is attached to manuscripts or made in sufficient time before publication. Checks for reprints should be made payable to The Transcript Company, Norman, Oklahoma.



PARKE, DAVIS & COMPANY DETROIT, MICHIGAN

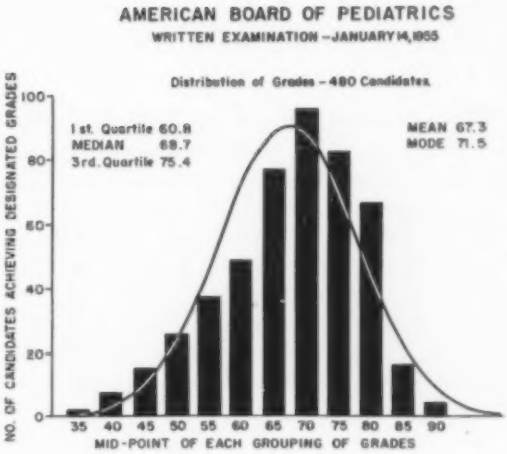
Editorials

The Mean, the Median and the Mode

The opposite graph[1] illustrates very nicely the frequency distribution curve discussed last month. In this case the variable is the grade that the examinee makes. The magnitude is the number of observations at each point on the variable when they are plotted in order. The curved line is called the frequency polygon and denotes the observations plotted in order. The rectangular figures in black constitute a histogram in which the observations are grouped around whole numbers in order. In both cases the base line (abscissa) denotes the characteristics being measured and the vertical scale (ordinate) reveals the frequency with which it occurs.

The mean is the average as we commonly use the term which is the quotient when the sum of all the grades is divided by the number of people making them. The median is the midpoint on the distribution curve with half the observations falling below and half falling above. The median rather than the mean may give a more accurate picture of what is desired. If one were interested in the average length of stay in the hospital of 100 consecutive patients who had had appendectomies and two of these patients had complications that required hospitalization for three months each, the median would more closely approximate the usual stay than would the mean. This would simply place two more people above the midpoint or move the midpoint back two places on the distribution curve. Two patients, however, accounting for 180 days of the total would make a great difference in the mean (average). The mode is the most fashionable or the point at which the greatest number of observations occur.

[1]Reprinted by permission of the Editors and the Charles C. Thomas Co. Publishers, from Pediatrics 16:732 (Nov.) 1955.



Social Security—Big Issue in '56

Every physician who is conscious of his duties as a citizen should now be taking an active interest in a timely issue which the American Medical Association considers of great importance—not only to the medical profession but to all of the American people.

That issue is HR 7225, a bill passed by the United States House of Representatives last summer near the end of the Congressional session. This bill, known as the Social Security Amendments of 1955, was first rushed through the House Ways and Means Committee without public hearings. Then it was passed in the House, by a vote of 372 to 31, under a suspension of the rules which barred amendments and limited debate to 40 minutes. The Senate Finance Committee, however, refused to take hasty action on a bill of such major importance. After hearing the many serious questions raised by Mrs. Hobby, then Secretary of the Department of Health, Education and Welfare, the Committee decided to hold extensive public hearings

during the second session of the 84th Congress.

Just what is this legislation that appears to be so politically attractive to individuals with an eye on the 1956 elections? Why was the House majority leadership so determined to avoid open hearings and normal debate? Let's take a brief look at the main provisions of the bill.

This is the legislation which would lower the Social Security retirement age for women from 65 to 62; extend monthly benefits for permanently and totally disabled children beyond the age of 18; expand compulsory social security coverage to all self-employed professional groups except physicians, and raise social security taxes over and above the increases already scheduled for the next 20 years. Those provisions alone demand careful study of their effects on the philosophy, scope and financial stability of our social security system.

The most controversial section of the bill, however, is the one which would make permanently and totally disabled persons eligible to receive their social security retirement benefits at age 50 instead of 65. It is this section which is of particular concern to the medical profession. It is of far greater concern than the question of voluntary or compulsory coverage of physicians under the social security system. This is a separate issue which we are not discussing in this editorial. The plan for a national system of permanent and total disability benefits has far more serious implications for medicine and the nation.

It raises questions such as these: Is there real need for a federal program? What are the facts on permanent and total disability? Won't this duplicate or overlap existing programs of assistance and rehabilitation? What effect will cash handouts have on a patient's incentive to be rehabilitated? Won't this extend federal control over physicians? —and, finally—How will this affect the future of medical practice? Will this lead, step by step, to the lowering and eventual elimination of the age-50 eligibility requirement; then, cash benefits for the dependents of those who are permanently and totally disabled; then, a temporary disability benefits program; then, cash benefits or direct government payments for hospital or medical costs, and then, ultimately, a full-fledged system of government health insurance?

These are but a few of the many grave quetions which already have been raised concerning this legislation. As physicians, we must be concerned over the medical aspects of the problem. As citizens, we also must be concerned over the trends and implications in the never-ending expansion of our social security system. The minority report of the House Ways and Means Committee expressed it this way:

"We do not believe that our committee has discharged its obligation to either the Congress or to the American people by its brief and closed-door consideration of this vital legislation. We have sought to point out the grave social and economic implications of the bill. We have dwelt at some length with the staggering ultimate costs of this developing program, because we do not believe that either the Congress or the public has any conception of its magnitude."

Our social security system now has reached the point where any further changes may have a profound influence on the nation's economic, social and political future. The time has come to face up to the question of just what social security should accomplish and just where it should stop. The Association strongly *urges* that the social security issue be taken out of the arena of vote-catching politics; that there be an objective, through study of social security in all its present and future aspects, and that the facts and realities emerging from such a study be used as the basis for a sound national decision on this vital issue. It especially protects precipitate action on the complex question of disability without thorough investigation of alternative mechanisms.

In our opinion, that is a reasonable, responsible policy that deserves the moral and intellectual support of every physician.

(Prepared under the authority of the offices of the Secretary-General Manager of the American Medical Association.)

Scientific Articles

Anatomic and Functional
ALTERATIONS *of the* CARPUS
Following Injury and Excision

JAMES K. STACK, M.D., F.A.C.S.

THE AUTHOR

Doctor Stack is Associate Professor of Bone and Joint Surgery, Northwestern University Medical School. He is attending surgeon, Passavant and Cook County Hospitals, Chicago. He is a diplomate, National Board of Medical Examiners and is secretary of the American Association for the Surgery of Trauma.

It would not be necessary to present the material which follows if all of us would keep in mind and put to use the known principles of the diagnosis and treatment of wrist injuries. Briefly, these principles are as follows—(1) Reject the diagnosis of sprain of the wrist until all other possible injuries have been ruled out. Fractures of the navicular bone and minor degrees of perilunar dislocation can be missed on superficial examination. The late results of such errors can be extremely disabling, and such wrists may masquerade for years under the guise of a so-called sprain. (2) Oblique x-ray films should always be taken in addition to the routine anteroposterior and lateral projections. Only in this way can the navicular bone be seen in its full length. In the routine views, the navicular is many times shortened; that is, the distal portion is superimposed upon the wrist, and fine fissures through the waist of the bone thereby obscured. (3) In instances where the navicular is suspected but the fracture cannot be proven on the original films, repeat the x-ray studies in 10 to 14 days. This will allow time for absorption of the bone to take place along the fracture line, and, thus, make the diagnosis perfectly clear. Many times a fracture will be easily visualized after this period when no line was seen in the films taken immediately after the injury. (4) Immobilize all suspected navicular fractures until it can be definitely proven that a fracture line does not exist. (5) Prolonged, uninterrupted, adequate immobilization of the wrist should be carried out until union occurs.

The late complications, most of which occur years and not months afterward, could, for the most part, be avoided if these simple rules were adhered to. Unfortunately, many of these injuries still go unrecognized until the complications become so evident that no one could miss them. These complications are the principle concern of this paper.

The carpal navicular and lunate work as a system. This system forms the intermediary joint between the radius and the capitate, and it is responsible in a large measure for the amplitude of movement that the wrist enjoys. This position, which makes these bones so important, also makes them vulnerable, for it places them in a wedge compressed between the forearm and the distal carpal row. These two bones (navicular and lunate) also participate in the formation of the carpal arches, both the transverse and the longitudinal. In fact, the lunate is the keystone of each. It is situated at the apex of the palmar groove, through which pass certain of the nerves, tendons and blood vessels to the hand and fingers. This groove is bounded by two pillars, the navicular and the greater multangular on the radial side, and the pisiform and the unciform on the ulnar side. These pillars are an important part of the thenar and hypothenar eminences.

The head of the capitate, i.e., its proximal end, is the common center of the movements of the wrist. It is a kind of rudder, merely

tilting, while the satellite bones around it describe a varied movement pattern. Recent fluoroscopic studies of the movement of various joints show that the range of motion in this part of the carpus is wider and more varied than formerly thought. The navicular and lunate, acting as a system, have an ability to conform with any position of the hand, and these bones are frequently caught compressed and fractured or dislocated when force is applied in any of their varied positions.

The carpus reacts to inflammation, whether traumatic or not, whether acute or chronic, in three general ways—(1) The acute onset is followed by capsular and ligamentous fibrosis. All the joints that make up the radial carpus, carpus and a carpometacarpus intercommunicate so that simple effusion, hemorrhage, suppuration, and the like, and the residual fibrosis will not be confined to any single space or joint, but will be widespread throughout the wrist. (2) By cystic change in the carpal bones, the distal end of the radius, and proximal ends of the metacarpals—these cystic areas are caused by the hyperemia induced by the primary lesion. Why it is so selective is not known, but the bones bearing the burden of movement and the direct application of forces are more frequently involved. In a way, it may be said that these involved parts never recover from the initial osteoporosis. The osteolytic action continues and localized replacement by fibrosis tissue takes place. The cavity usually contains, besides fibrous tissue, amorphous, calcific material and a little fluid. The relatively dense confining layer seen in the x-ray will contain some necrotic bone, and the hyaline cartilage overlying the cystic defect will be in a varying state of necrosis. There may or may not be attempts at replacement with fibrocartilage. The presence of these cysts induced originally by the initial hyperemia serve also to continue it because of the necessity to dissolve and carry away the contents of the cavity and to effect its replacement by new bone, if possible. (3) By arthritic change—This change may be brought about by the cystic lesion described before resulting in the necrosis of overlying cartilage, or the cartilage may be directly destroyed by the friction of necrotic bone or a fragment acting as a foreign body in the working mechanism of the joint. This is the so-called "sand in the bearing" picture, which is a traumatic arthritis. Whatever the basic cause, the end result is the approximation of bony surfaces and the mixture of fibrosis and bony ankylosis.

This fibrosis, cystic change and arthritis may also be brought about as a slowly-developing, chronic process over a period of years, such as the gradual re-alignment of the carpal bones necessitated by the loss of one of the two members of the navicular-lunate system. For example, if a substantial fragment of the navicular, or the entire navicular, is removed, a certain re-adjustment will result. This will consist principally in the attempt of the capitate to approximate the articular surface of the radius. This is caused by the action of the tendons of the wrist and the hand, and the gradual shortening and tightening of the supporting ligaments of the wrist. As this goes on, the lunate will gradually be displaced toward the ulnar side of the wrist, the navicular-lunate system will be disrupted, and the lunate alone will not be able to describe a normal movement pattern around the proximal end of the capitate.

The lunate, in effect, is trapped and becomes actually a supernumerary bone of the proximal row. Its attempts to conform to the demands made upon it result in a stretching or overstrain of the ligaments which support it, and this, in turn, initiates a chronic, inflammatory process. In time, this will be followed by the fibrosis, the cystic change and the cartilaginous degeneration described before. The degeneration will be enhanced by the scraping effect of any cartilaginous surface that is working out of alignment, and, in this sense, it is analogous to the chondromalacia of the patella that develops when the bone rides laterally over the femoral condyle in cases of extreme valgus deformity of the knee. It is also seen in those instances where the alignment of the leg above the ankle has been altered in a medial lateral direction, so that a cross-strain is borne upon this weight-bearing joint. It is true that the wrist, being a non-weight-bearing joint, will not react as quickly as the others, but, certainly, the direct and torsional forces applied to the wrist of a laborer will

Fig. 1

Fig. 2

Fig. 3 The anatomic and functional re-adjustment that takes place following excision of the navicular and lunate bones. Above: Flexion and extension. Below: Radial and ulnar deviation.

Fig. 1 Extensive cystic and arthritic change in the capitate bone and radiocarpal joint. Note in the upper illustration the dislocation of the lunate volarward. It has been gradually forced out of position by the pressure of the capitate in its effort to fill the space caused by the navicular collapse.

Fig. 2 Collapse of the necrotic navicular. Note the ulnar displacement of the lunate and the proximity of the multingular bones to the styloid process of the radius. This is caused by the general shortening of the carpus and the attempt of the capitate to articulate with the radius.

be almost as great as those applied to the lower extremity in just ordinary weight-bearing activity.

Having these inevitable and disabling pathologic changes in mind, what is the proper management during the various stages of complications? When the original diagnosis has not been made, and we are forced to prescribe treatment, what are the methods that should be used in the various phases of these complications?

The varying situations that must be met will vary from simple non-union with no other change to a complete degenerative arthritis involving practically the whole wrist.

(1) In the case of non-union seen, let us say, four to six months after the fracture, with both fragments viable, simple immobilization in an adequate plaster cast should be tried. The cast should permit free motion of all the joints of the fingers, but should permit no motion in the thumb except in its interphalangeal joint. The wrist should be held in a position of comfortable dorsiflexion and neutral, as far as radial and ulnar deviation is concerned. It should extend upward to the junction of the middle and upper thirds of the forearm. This cast should be continued for nine to 12 months. (2) If non-union still persists over this period of

time, or, if a patient presents himself with an established non-union and substantial absorption along the fracture line, a drilling procedure or bone-grafting procedure is in order. This is followed by prolonged immobilization until union is complete. If these methods are to succeed, both fragments must be viable, and the separation must be minimal. Such an attempt to obtain union is particularly important in the wrist of a laboring man. If, however, his occupation and his habits and avocations place no great demand on the wrist, it may be permissible to reject treatment and allow the non-union to persist. The degenerative changes may be very slow in development under these circumstances, and may be minimal, so that pain or discomfort will be experienced only when the wrist is put to hard or unusual use. (3) In the older cases of non-union, with both fragments viable, but with slight to moderate cystic change along the fracture line and no arthritic change, bone-grafting and immobilization are the methods of choice. (4) Those cases in which there is necrosis of either fragment, substantial cystic change, and definite arthritic change in the radial carpal articulation are best treated by excision of the proximal row of the carpal bones, followed by early motion and intensive physical therapy aid. (5) Occasionally, there will be seen a wrist in which the navicular fragments are necrotic and collapsed, cystic change present in many of the other carpal bones, and so much arthritic change that the radial carpal and the intercarpal spaces can hardly be defined. These wrists should be fused in the position of function, being careful to preserve the distal radial ulnar joint so that supination and pronation of the forearm will not be affected.

REFERENCES

1. Destot, E.: *Injuries of the Wrist: A Radiologic Study*, London, Ernest Benn, Ltd., 1925.
2. Stack, James K.: End Results of Excision of the Carpal Bones, Arch. of Surg., August, 1948, Vol. 57, pp. 245-251.
3. Murray, Gordon: End Results of Bone-Grafting for Non-Union of the Carpal Navicular, J. Bone & J. Surg., 1946, Vol. 28, p. 749.
4. Soto-Hall, B.; Haldeman, K. C.: The Conservative and Operative Treatment of Fractures of the Carpal Scaphoid Navicular, J. Bone & Joint Surg., 1941, Vol. 23, p. 841.
5. Cane, E. F.: Retrolunar Dislocation of the Capitate with Fracture or Subluxation of the Navicular Bone, J. Bone & Joint Surg., 1941, Vol. 23, p. 830.
6. Finn, H. G. and Palmberg, K. J.: Fractures of the Carpal Scaphoid: A Study of Ten Cases, Naval Med. Bulletin, 1944, Vol. 42, p. 38.
7. Henry, M. G.: Fractures of the Carpal Scaphoid Bone in Industry and the Military Service, Arch. Surg., 1944, Vol. 48, p. 278.
8. Soto-Hall, R.: Fractures of the Carpal Scaphoid, J.A.M.A., 1945, Vol. 129:335.
9. Edelstein, J. M.: The Treatment of Un-united Fractures of the Carpal Navicular, J. Bone & Joint Surg., 1949, Vol. 21, p. 902.

Indications, Technique and Aftercare of TRACHEOTOMY

ROBERT M. SHEPARD, JR., M.D.

THE AUTHOR

Doctor Shepard graduated from Tulane Universtity School of Medicine and served his internship and four year residency at Charity Hospital in New Orleans. He is engaged in the practice of general surgery in Tulsa.

This paper is based on 60 tracheotomies performed and followed by me. The technique to be described was used on all cases. In the day-to-day, and sometimes hour-to-hour, observation and management of the many problems and complications which attend tracheotomies, experiences were gained which form the basis of this report.

Indications for tracheotomy may be broadly grouped into three classes: (1) upper respiratory obstruction, (2) muscular paralyses with inability to handle secretions, and (3) as an aid to breathing and maintaining respiratory exchange in chest and lung injuries. The airway may become obstructed from glottic edema, laryngeal paralysis, foreign bodies, and tumors of the hypopharynx, larynx, trachea or thyroid. The most common of these, in my experience, is glottic edema from acute laryngotracheitis in young children. There were seven cases of this, with six recoveries and one death. The decision to perform tracheotomy in an acutely ill child is a difficult one to make. If one waits too long, death may occur from fatigue, anoxia and complete respiratory obstruction. On the other hand, tracheotomy is difficult

technically on a small infant, and even greater are the difficulties of constantly maintaining an open airway through a tube smaller than a soda straw. The definite risk of tracheotomy in this age group is shown by two cases who died from a plug of mucous in the small tube.

My procedure in these situations is to perform immediate tracheotomy if exhaustion, extreme restlessness, pale shock-like state, slowing respirations, or marked sternal and neck retractions are present. One should never wait for cyanosis as death may come first. If the child is still vigorous and does not seem in urgent danger, one may try a few hours in a well-humidified oxygen tent with the atmosphere saturated with alevaire. Antihistamines and decongestant nose drops, but no sedation, are used. This program is continued as long as the child maintains itself or shows any improvement. Tracheotomy is done at the first signs of worsening or exhaustion.

Obstruction from tumors comprise six cases of my series. Two of these were advanced carcinoma of the larynx and three were from thyroid tumors. Of the thyroid tumors, two were carcinoma and one a benign adenoma which nearly caused the patient's death from acute obstruction before an airway could be established. There is a fairly constant pattern in these cases. The patient is conscious of difficult breathing, particularly on lying down, for many weeks or months, before a sudden or acute obstruction occurs, apparently from secondary edema. Three of my six cases were done as acute emergencies on unconscious patients who had suddenly obstructed from a tumor known to be present for a long time.

Tracheotomy is of value in poliomyelitis, cerebral vascular accidents, barbiturate poisoning, tetanus, botulism, status asthmaticus and after radical mouth and neck surgery. In these conditions, excessive secretions are formed which cannot be handled by the patient, who is already handicapped by paralysis, poor or absent cough reflex and inability to turn or to communicate his desires. Tracheotomy may usually be performed unhurriedly in these conditions. It facilitates nursing care greatly and enables the attendants to keep the airway free and clean of secretions at all times. If done on a patient with poliomyelitis, one should be careful that the opening is established high enough to be handled easily in a respirator.

Tracheotomy has been found of aid in traumatic tracheobronchial and chest injuries (nine cases), pulmonary edema (two cases), and postpneumonectomy (two cases). A tracheotomy bypasses approximately 300 cc. of dead air space in the average adult, and this makes a great deal of difference to a person laboring to survive with one lung removed, crushed, or filled with fluid. The ineffecutal cough and increased secretions common to these injuries are easily handled by the direct catheter suction thus afforded.

The majority of tracheotomies are not done in the operating room. In 60 cases, 16 were done with operating room facilities, 29 were done in bed, and 15 in a respirator. Since circumstances are usually less than ideal, one must be prepared to do tracheotomy with little or no assistance, with only a few instruments, a token of sterile technique, under poor light, a minimum of anesthesia, on an unconscious or struggling patient, where haste is essential. Under these circumstances, only a direct, simple technique will do. A pack containing knife, scissors, hemostats, Allis forceps, towels, syringes, gloves, suture, and numbers one, three and five tubes should always be sterile and ready in an accessible place.

A midline incision is to be preferred to the transverse. It is easier, faster, can be performed under all circumstances, bleeding is less, tissue planes are disturbed less, there is no dependent pocket under the lower flap in which secretions can collect and cause infection, and the scar is satisfactory. The only advantage of the transverse incision is an allegedly better scar, but this advantage does not out-weigh its disadvantages. I have had to do a plastic on only one scar in this series, on an 18 year old girl who wished a better cosmetic result.

A folded sheet or small sand bag is placed between the shoulder blades and the head allowed to drop back in mild hyperextension. After infiltration with local anesthetic, a midline incision is made through the skin and platysma with its upper end about one cm. below the cricoid cartilage. With experi-

ence this incision can be kept short—about two to three centimeters. The edges of the skin are grasped with Allis tissue forceps and separated and tented up. Being careful to keep in the exact midline, closed scissors are thrust into the subcutaneous tissues and the blades strongly separated in the direction of the incision. The tissues so separated are grasped with a second pair of Allis forceps, the first being dropped or removed for latter application. The subcutaneous tissues are tented up and separated by traction on the Allises while the scissors are again separated in the midline, separating the strap muscles, which in their turn are grasped with Allises and tented up. This brings into view the trachea and isthmus of the thyroid covered with areolar tissue, which in its turn is separated until the trachea is bare. If it is desired to keep the tracheotomy high, the thyroid isthmus is partially divided between Allises. After the trachea has been cleaned it is incised in the midline, two cartilaginous rings being cut. The edges of the incision are again grasped with Allis forceps and separated while a tracheotomy tube is inserted.

It is seldom necessary to ligate a single vessel in this procedure. Occasionally bridging vessels between the anterior jugulars or other aberrant vessels will require ligation, but excessive bleeding is usually indicative of having strayed from the midline. After the initial incision one should orient oneself frequently by palpating the trachea and thus be sure of the location of the midline.

After the tracheotomy tube has been inserted, all blood and secretions are aspirated from the trachea and any bleeders ligated if necessary. Two or three mattress sutures of silk are then placed in the skin. The deep tissues are not sutured and the skin should be left very loose about the tube to permit free drainage and to prevent subcutaneous emphysema.

The size tube to use in any individual patient is somewhat a matter of experience. All sizes should always be available and the final selection may be made after the trachea is exposed. Small infants require a 0 to one size, children two years old and over will usually accept a number two. At five a number three may be selected, and after the age of eight, a number four. An adult woman should have a number five and an adult man a number six. The largest acceptable size should be used because of the mechanical difficulties of aspirating and keeping open a small tube.

The technique described is sufficiently rapid, even under the most extreme circumstances, provided the tracheotomy pack and tubes are available and open. If they are not, a life-saving cricothyroid tracheotomy may be performed with only a knife. A knife blade is plunged transversely between the palpated thyroid and the cricoid cartilages, through the cricothyroid membrane. The knife handle is then placed into the trachea and twisted to a longitudinal position. As soon as conditions permit, a second tracheotomy should be performed in the usual position and the first incision closed. If it is used as a permanent site, laryngeal stenosis will probably result.

Postoperative care of a tracheotomized patient requires both knowledge and vigilance. Specially-trained nurses are greatly to be desired. In my series, three patients were lost because of mucous plugs occluding the tube and in two of these a special nurse was by the bedside at the time!

A beveled catheter for suction should be constructed by cutting and trimming the end of an ordinary French catheter. Its size depends on the size of the tube. A small hole may be cut toward the bell end, or a Y tube may be used as a connector so that suction may be made and broken with the thumb. By twisting the tracheotomy tube with one hand, the catheter may be "pointed" down the right or left bronchus to aspirate either side. Remember that breathing is difficult or impossible during suction so that each aspiration should be brief. The airway should be suctioned as often as necessary to keep it free of secretion. Oxygen is administered through a bent 18 gauge needle placed in the tracheotomy tube opening.

The inner cannula should be removed at least every two hours at first, then several times a day for cleaning. It should never be left out, as then the outer cannula may become encrusted and obstructed. Pipe cleaners are very useful for cleaning the cannula. I prefer not to change the outer cannula for

72 hours, if possible. At the end of this time the sinus tract has become formed and the lips of the tracheal incision will remain open for easy passage of the replacement tube. The outer tube may then be replaced as often as necessary to maintain a clean and neat tracheotomy.

The atmosphere should be kept as humid as posible with steam or other sources of water vapor. This substitutes for the humidifying action of the upper respiratory tract which has been bypassed. If humidification is not possible, one should instill 2 to 5 cc. of saline or Ringer's solution down the tracheotomy with a medicine dropper every two to four hours.

I should like to warn of one circumstance which may be both puzzling and dangerous because it was apparently the cause of death in two cases. The patient will exhibit difficult respirations, restlessness and perhaps cyanosis. Suctioning obtains little mucous but produces much relief, but after a short time the episode will be repeated with ultimate asphyxiation of the patient if suction is not repeated in time. I believe the cause of this is a large plug of inspissated mucous which occludes the end of the tracheotomy tube. When the suction catheter is passed this plug is dislodged downward, but not removed, and it soon makes its way back to the end of the tracheotomy tube. If one suspects this is the case, the mucuous plug may often be removed by removing the outer and inner cannulas and suctioning directly down the sinus with the catheter. If the plug cannot be obtained by this maneuver, the patient should be immediately bronchoscoped. Bronchoscopy is easily done through the tracheotomy sinus.

When the tracheotomy is no longer necessary, decannulation may be started by daily inserting a smaller size tube until a size one or two is in place. The last 24 hours the opening of this may be taped over to entirely accustom the patient to breathing through his nose again, after which the tube may be removed completely. One should not make the mistake of taping or corking the tube before the smallest one possible is in place. If a large size tube is completely occluding the trachea and this is then taped or corked, one could expect the patient to show great distress and the erroneous conclusion may be reached that the patient cannot tolerate decannulation.

The wound needs no care after the tube is removed. The sinus is usually closed in 24 hours and the wound is epithelized and healed in a few days. No sutures are necessary and any one may expect an acceptable scar.

Joins School of Medicine Staff

Three professors joined the fulltime faculty of the University of Oklahoma School of Medicine during November.

Dr. William Seeman has assumed the newly-created position of Associate Professor of Medical Psychology in the Department of Psychiatry. He has been Chief of the Clinical Psychology Department of the Mayo Clinic, Rochester, Minn., since 1950.

Dr.H Herbert H. Kent has been appointed Associate Professor of Physical Medicine and will instruct medical students and students in the new physical therapy school. Dr. Kent has been Chief of the Physical Medicine and Rehabilitation Department of the VA Hospital in Indianapolis for the last six years.

Dr. Earl G. Larsen has been appointed Assistant Professor of Biochemistry. He has been a research Associate in the Department of Chemistry at Wayne University College of Medicine, Detroit.

Abridged OKLAHOMA LIFE TABLES, *1949-1951*

JOHN C. BELCHER, Ph.D., and JAMES D. TARVER, Ph.D.

THE AUTHORS

John C. Belcher, Ph.D. and James D. Tarver, Ph.D. were co-authors of the explanatory article on the life tables. Doctor Belcher, formerly associate professor of Sociology and Rural Life at Oklahoma A. and M. College, is now with the University of Georgia. Doctor Tarver is also associated with the Department of Sociology and Rural Life at Oklahoma A. and M.

The improvement of the health of the people in Oklahoma, especially the decline in infant mortality and increase in longevity, is of vital concern to the Oklahoma State Medical Association, the Oklahoma State Department of Health, and all citizens of the State. Life tables make it possible to measure the health progress of not only the total population but also the various subgroups which compose it. Age-specific death rates and average life expectancy may be used in comparing Oklahoma with other states as well as for determining changes which have occurred within the State over a period of years.

Life tables are also useful as a means of estimating the number of survivors in a given population at future dates. By comparing the number of survivors, computed from life tables with actual population counts, it is possible to estimate the net migration of people from or to certain areas during the time interval under consideration.

The purpose of this paper is to make available life table data, based on 1949, 1950, and 1951 deaths, for the Oklahoma population cross-classified by race, residence, and sex.

Need to Distinguish between the Life Span and Life Expectancy. In 1900, the average infant born in the United States could expect to live approximately 47 years. By 1950, life expectancy in this country at birth had reached 68.4 years.[1] The greater part of the increase in longevity has been the result of saving the lives of infants and children. A larger proportion of the population survives a larger part of the normal life span than in the past. Many people have assumed that similar increases in life expectancy may be anticipated with further advancements in medical care along with improvements in diet, housing, and sanitation. However, a study of life tables shows that it is quite improbable that the second half of the present century can duplicate the accomplishments of the first half in improving the average length of life.[2] The reason for this statement is that man is a finite being and the "life span"—the extreme limit set to human life by old age—has probably not changed since Biblical times.[3] Barring all accidents and diseases, every individual would eventually die. Life expectancy at birth can, of course, never exceed the life span, and life expectancy in this nation already may be so high for some groups that little increase can be expected unless the life span is first increased. There is still considerable opportunity to lower the death rates of certain groups, but, "Any appreciable increase in the expectation of life at ages over 40 seems to await the conquering of the degenerative diseases of the circulatory system, the respiratory system, and the other vital organs."[4] Improvements in longevity during the past 50 years have greatly increased the chances of survival to the forties and fifties and even to the threshold of old age, but between 1900 and 1950, the expectation of life at age 65 only increased from 11.9 to 14.1 years.[5] At age 85, it is doubtful that there has been any statistically significant change in life expectancy in the past century.

How Life Expectancy Has Increased. Table I shows the changes in the death rates for the United States at different ages by decades between 1900 and 1950. It may be noted that declines in infant mortality, and the death rates of children, youth, and young adults have been truly phenomenal. How-

ever, the decreases in death rates at the advanced ages have been relatively minor. Through more adequate medical care and improved living conditions, infant and maternal mortality have been greatly reduced. (The communicable diseases which two generations ago took a terrific toll of children and young adults largely have been brought under control.) Many of the leading causes of death at the beginning of the Twentieth Century such as typhoid, scarlet fever, diphtheria, and smallpox have been almost eradicated from our society. Consequently, an increasing proportion of the population is reaching the advanced ages where the as yet unconquered degenerative diseases reap a prodigious harvest. In the United States in 1900, only 66 out of every 100 newly born infants could expect to live to age 40, but by 1950, the chance of survival to age 40 had increased to 92 in 100.[6]

Still, the life tables presented here do indicate certain segments of the population of Oklahoma where further increases in longevity can be expected. Except for differentials in mortality related to age, and to some extent sex, the differences in the death rates from one group to another tend to be environmentally determined. Thus, it is logical to suppose that the groups with the highest death rates can have them lowered sufficiently to compare favorably with those groups now experiencing low mortality. (Accomplishing this end might be considered the major goal of medical practitioners.)

Interpretation of Life Tables for Oklahoma, 1949-1951. An analysis of the eight Abridged Oklahoma Life Tables presented here (Tables II-IX) permits several conclusions to be drawn:

1. As has been found in numerous studies in other areas, females have longer life expectancy than males, whites live on the average longer than nonwhites, and the life expectation of rural persons is greater than that of urban residents.

2. Rural white females have the longest expectation of life (74 years at birth); whereas, the lowest average length of life is the 60 years for the urban nonwhite male.

3. Mortality rates are high for all groups the first year of life. After age one, these rates drop rapidly and reach a low point at approximately 10 years of age. From age 10 through the twenties, death rates remain low but continue to steadily increase. With increasing age, the mortality rates progressively become greater and by age 75, the rates are very high.

4. Because mortality rates are high the first year of life, the average expectation of life is greater at age one than at birth. Of course, in general, with increasing age the average future lifetime declines until it reaches a figure of around five years for those age 85.

5. In the upper age brackets, the well-known differentials in life expectancy tend

DEATH RATES BY AGE: DEATH-REGISTRATION STATES, 1900-1950

(Exclusive of fetal deaths. Rates per 1,000 estimated midyear population in each specified group)

Year	Total	Under 1 Year	1-4 Years	5-14 Years	15-24 Years	25-34 Years	35-44 Years	45-54 Years	55-64 Years	65-74 Years	75-84 Years	85 Years and Over
1950	9.6	33.0	1.4	0.6	1.3	1.8	3.6	8.5	19.1	40.7	93.3	202.0
1940	10.8	54.9	2.9	1.0	2.0	3.1	5.2	10.6	22.3	48.0	112.0	235.7
1930	11.3	69.0	5.6	1.7	3.3	4.7	6.8	12.2	24.0	51.4	112.7	228.0
1920	13.0	92.3	9.9	2.6	4.9	6.8	8.1	12.2	23.6	52.5	118.9	248.3
1910	14.7	131.8	14.0	2.9	4.5	6.5	9.0	13.7	26.2	55.6	122.2	250.3
1900	17.2	162.4	19.8	3.9	5.9	8.2	10.2	15.0	27.2	56.4	123.3	260.9

NOTE: Death-registration States increased in number from only 10 States and the District of Columbia in 1900 to the entire continental United States by 1933.

Source: Vital Statistics of the United States, 1950, Volume 1, U. S. Department of Health, Education, and Welfare, Public Health Service, 1954, p. 190.

TABLE I

LIFE TABLE FOR URBAN, WHITE MALES, OKLAHOMA, 1949-1951

Year of Age	Mortality Rate	Of 100,000 Born Alive		Stationary Population		Average Future Lifetime
Age Interval	Number dying per 1000 alive at beginning of year of age	Number living at beginning of year of age	Number dying during year of age	In year of age	In year of age and all later years	Average number of years of life remaining at beginning of year of age
(1)	(2)	(3)	(4)	(5)	(6)	(7)
x to x + 1	$_nq_x$	l_x	d_x	L_x	T_x	e_x
Under 1	.03388	100,000	3,388	98,305	6,620,863	66.21
1-4	.00556	96,612	537	385,222	6,522,558	67.51
5-9	.00410	96,075	394	479,319	6,137,336	63.88
10-14	.00289	95,681	277	479,239	5,658,017	59.13
15-19	.00733	95,404	699	474,864	5,178,778	54.28
20-24	.00807	94,705	764	471,605	4,703,914	49.67
25-29	.00740	93,941	695	467,699	4,232,309	45.05
30-34	.01045	93,246	974	463,810	3,764,610	40.37
35-39	.01536	92,272	1.417	457,835	3,300,800	35.77
40-44	.02292	90,855	2,082	449,288	2,842,965	31.29
45-49	.03717	88,773	3,300	436,277	2,393,677	26.96
50-54	.05878	85,473	5,024	415,584	1,957,400	22.90
55-59	.08938	80,449	7,191	385,349	1,541,816	19.17
60-64	.13714	73,258	10,047	342,445	1,156,467	15.79
65-69	.18255	63,211	11,539	288,403	814,022	12.88
70-74	.26247	51,672	13,562	225,290	525,619	10.17
75-84	.68431	38,110	26,079	247,349	300,329	7.88
85 and over	1.0000	12,031	12,031	52,980	52,980	4.40

TABLE II

LIFE TABLE FOR RURAL, WHITE MALES, OKLAHOMA, 1949-1951

Under 1	.02841	100,000	2,841	98,738	6,873,386	68.73
1-4	.00730	97,159	709	387,009	6,774,648	69.73
5-9	.00380	96,450	367	481,627	6,387,639	66.23
10-14	.00407	96,083	391	479,755	5,906,012	61.47
15-19	.00724	95,692	693	477,273	5,426,257	56.71
20-24	.01234	94,999	1,172	472,010	4,948,984	52.10
25-29	.00989	93,827	928	466,801	4,476,974	47.72
30-34	.01107	92,899	1,028	461,815	4,010,173	43.17
35-39	.01456	91,871	1,338	456,499	3,548,358	38.62
40-44	.01715	90,533	1,553	449,233	3,091,859	34.15
45-49	.02850	88,980	2,536	439,058	2,642,626	29.70
50-54	.04435	86,444	3,834	423,272	2,203,568	25.49
55-59	.07119	82,610	5,881	399,280	1,780,296	21.55
60-64	.08927	76,729	6,850	367,568	1,381,006	18.00
65-69	.13929	69,879	9,733	326,260	1,013,438	14.50
70-74	.20765	60,146	12,489	270,641	687,178	11.43
75-84	.61511	47,657	29,314	330,299	416,537	8.74
85 and over	1.00000	18,343	18,343	86,248	86,248	4.70

TABLE III

LIFE TABLE FOR URBAN WHITE FEMALES, OKLAHOMA, 1949-1951

Year of Age	Mortality Rate	Of 100,000 Born Alive		Stationary Population		Average Future Lifetime
Age Interval	Number dying per 1000 alive at beginning of year of age	Number living at beginning of year of age	Number dying during year of age	In year of age	In year of age and all later years	Average number of years of life remaining at beginning of year of age
(1)	(2)	(3)	(4)	(5)	(6)	(7)
x to x + 1	$_nq_x$	l_x	d_x	L_x	T_x	e_x
Under 1	.02541	100,000	2,541	98,733	7,372,081	73.72
1-4	.00541	97,459	440	389,725	7,273,348	74.63
5-9	.00263	97,019	255	483,871	6,883,623	70.95
10-14	.00190	96,764	184	482,940	6,399,752	66.14
15-19	.00319	96,580	308	482,003	5,916,812	61.26
20-24	.00379	96,272	365	480,896	5,434,809	56.45
25-29	.00438	95,907	420	478,360	4,953,913	51.65
30-34	.00615	95,487	587	476,075	4,475,553	46.87
35-39	.00903	94,900	857	472,697	3,999,478	42.14
40-44	.01279	94,043	1,203	467,548	3,526,781	37.50
45-49	.01711	92,840	1,588	460,423	3,059,233	32.95
50-54	.02586	91,252	2,360	450,898	2,598,810	28.48
55-59	.04011	88,892	3,565	436,139	2,147,912	24.16
60-64	.06094	85,327	5,200	414,475	1,711,773	20.06
65-69	.09851	80,127	7,893	382,024	1,297,298	16.19
70-74	.15871	72,234	11,464	333,838	915,274	12.67
75-84	.54768	60,770	33,283	445,532	581,436	9.57
85 and over	1.00000	27,487	27,487	135,904	135,904	4.94

TABLE IV

LIFE TABLE FOR RURAL, WHITE FEMALES, OKLAHOMA, 1949-1951

Under 1	.02310	100,000	2,310	98,848	7,397,141	73.97
1-4	.00563	97,690	550	389,794	7,298,293	74.71
5-9	.00333	97,140	323	483,533	6,908,499	71.12
10-14	.00244	96,817	236	482,618	6,424,966	66.36
15-19	.00381	96,581	368	482,307	5,942,348	61.53
20-24	.00485	96,213	467	480,453	5,460,041	56.75
25-29	.00511	95,746	489	477,539	4,979,588	52.01
30-34	.00607	95,257	578	474,938	4,502,049	47.26
35-39	.00830	94,679	786	471,789	4,027,111	42.53
40-44	.01093	93,893	1,026	466,788	3,555,322	37.87
45-49	.01755	92,867	1,630	460,712	3,088,534	33.26
50-54	.02314	91,237	2,111	451,165	2,627,822	28.80
55-59	.03468	89,126	3,091	438,440	2,176,657	24.42
60-64	.05329	86,035	4,585	419,449	1,738,217	20.20
65-69	.09771	81,450	7,958	388,498	1,318,768	16.19
70-74	.15035	73,492	11,050	341,186	930,270	12.66
75-84	.55345	62,442	34,559	455,713	589,084	9.43
85 and over	1.00000	27,883	27,883	133,371	133,371	4.78

TABLE V

LIFE TABLE FOR URBAN, NON-WHITE MALES, OKLAHOMA, 1949-1951

Year of Age	Mortality Rate	Of 100,000 Born Alive		Stationary Population		Average Future Lifetime
Age Interval	Number dying per 1000 alive at beginning of year of age	Number living at beginning of year of age	Number dying during year of age	In year of age	In year of age and all later years	Average number of years of life remaining at beginning of year of age
(1)	(2)	(3)	(4)	(5)	(6)	(7)
x to x + 1	$_nq_x$	l_x	d_x	L_x	T_x	e_x
Under 1	.05311	100,000	5,311	97,364	5,995,285	59.95
1-4	.01178	94,689	1,115	376,562	5,897,921	62.29
5-9	.00531	93,574	497	467,105	5,521,359	59.01
10-14	.00614	93,077	571	463,851	5,054,254	54.30
15-19	.01050	92,506	971	460,190	4,590,403	49.62
20-24	.02167	91,535	1,984	453,071	4,130,213	45.12
25-29	.01711	89,551	1,532	444,187	3,677,142	41.06
30-34	.02164	88,019	1,905	435,827	3,232,955	36.73
35-39	.03225	86,114	2,777	424,099	2,797,128	32.48
40-44	.04588	83,337	3,824	407,806	2,373,029	28.48
45-49	.06127	79,513	4,872	386,207	1,965,223	24.72
50-54	.09386	74,641	7,006	356,739	1,579,016	21.15
55-59	.13577	67,635	9,183	315,654	1,222,277	18.07
60-64	.16851	58,452	9,850	268,737	906,623	15.51
65-69	.20456	48,602	9,942	219,083	637,886	13.12
70-74	.27404	38,660	10,594	167,399	418,803	10.83
75-84	.62471	28,066	17,533	192,863	251,404	8.96
85 and over	1.00000	10,533	10,533	58,541	58,541	5.56

TABLE VI

LIFE TABLE FOR RURAL, NON-WHITE MALES, OKLAHOMA, 1949-1951

Under 1	.04235	100,000	4,235	97,908	6,246,909	62.47
1-4	.01522	95,765	1,458	380,480	6,149,001	64.21
5-9	.00397	94,307	374	470,440	5,768,521	61.17
10-14	.00712	93,933	669	468,160	5,298,081	56.40
15-19	.00922	93,264	860	464,614	4,829,921	51.79
20-24	.01453	92,404	1,343	458,988	4,365,307	47.24
25-29	.02881	91,061	2,623	449,067	3,906,319	42.90
30-34	.03123	88,438	2,762	435,784	3,457,252	39.09
35-39	.02673	85,676	2,290	422,977	3,021,468	35.27
40-44	.03845	83,386	3,207	409,422	2,598,491	31.16
45-49	.05926	80,179	4,751	389,746	2,189,069	27.30
50-54	.06756	75,428	5,096	365,226	1,799,323	23.85
55-59	.08531	70,332	6,000	337,553	1,434,097	20.39
60-64	.11855	64,332	7,627	303,635	1,096,544	17.05
65-69	.15441	56,705	8,756	262,683	792,909	13.98
70-74	.23960	47,949	11,489	211,884	530,226	11.06
75-84	.62647	36,460	22,841	250,142	318,342	8.73
85 and over	1.00000	13,619	13,619	68,200	68,200	5.01

TABLE VII

LIFE TABLE FOR URBAN, NON-WHITE FEMALES, OKLAHOMA, 1949-1951

Year of Age	Mortality Rate	Of 100,000 Born Alive		Stationary Population		Average Future Lifetime
Age Interval	Number dying per 1000 alive at beginning of year of age	Number living at beginning of year of age	Number dying during year of age	In year of age	In year of age and all later years	Average number of years of life remaining at beginning of year of age
(1)	(2)	(3)	(4)	(5)	(6)	(7)
x to x + 1	$_nq_x$	l_x	d_x	L_x	T_x	e_x
Under 1	.03774	100,000	3,774	98,125	6,458,503	64.59
1-4	.00758	96,226	729	383,482	6,360,378	66.10
5-9	.00272	95,497	260	477,064	5,976,896	62.59
10-14	.00459	95,237	437	475,517	5,499,832	57.75
15-19	.00952	94,800	902	471,511	5,024,315	53.00
20-24	.01330	93,898	1,249	466,741	4,552,802	48.49
25-29	.01422	92,649	1,317	460,007	4,086,063	44.10
30-34	.02166	91,332	1,978	452,114	3,626,056	39.70
35-39	.02926	89,354	2,614	440,661	3,173,942	35.52
40-44	.04238	86,740	3,676	425,168	2,733,281	31.51
45-49	.05541	83,064	4,603	404,624	2,308,113	27.79
50-54	.08915	78,461	6,995	375,853	1,903,489	24.26
55-59	.10908	71,466	7,796	338,957	1,527,636	21.38
60-64	.12952	63,670	8,247	298,826	1,188,679	18.67
65-69	.11046	55,423	6,122	262,657	889,853	16.06
70-74	.20444	49,301	10,079	222,244	627,196	12.72
75-84	.53306	39,222	20,908	290,841	404,952	10.32
85 and over	1.00000	18,314	18,314	114,111	114,111	6.23

TABLE VIII

LIFE TABLE FOR RURAL, NON-WHITE FEMALES, OKLAHOMA, 1949-1951

Under 1	.03693	100,000	3,693	98,171	6,564,871	65.65
1-4	.01151	96,307	1,108	382,861	6,466,700	67.15
5-9	.00441	95,199	420	475,113	6,083,839	63.91
10-14	.00382	94,779	362	473,203	5,608,726	59.18
15-19	.00943	94,417	890	469,905	5,135,523	54.39
20-24	.01533	93,527	1,434	464,529	4,665,618	49.89
25-29	.01670	92,093	1,538	456,786	4,201,089	45.62
30-34	.01961	90,555	1,776	448,598	3,744,303	41.35
35-39	.03016	88,779	2,678	437,796	3,295,705	37.12
40-45	.04174	86,101	3,594	422,178	2,857,909	33.19
45-45	.05282	82,507	4,358	402,364	2,435,731	29.52
50-54	.05715	78,149	4,466	380,279	2,033,367	26.02
55-59	.07635	73,683	5,626	355,222	1,653,088	22.44
60-64	.09151	68,057	6,228	325,647	1,297,866	19.07
65-69	.12073	61,829	7,465	291,488	972,219	15.72
70-74	.18973	54,364	10,314	247,054	680,731	12.52
75-84	.60453	44,050	26,630	308,150	433,677	9.85
85 and over	1.00000	17,420	17,420	125,527	125,527	7.21

TABLE IX

to disappear. For example, above the age of 70, there are no differences in length of life by residence and those by sex are relatively small. The most significant differential at age 85 is that nonwhites live longer than whites. Life tables constructed for other states usually show this same relationship in the advanced ages.

Methodological Note. This study has presented selected life table values computed for the white and nonwhite, male and female, and rural and urban populations of Oklahoma, based on mortality experience for the three years 1949, 1950, and 1951. The Reed-Merrell method for constructing abridged life tables was followed.[7]

The Oklahoma State Department of Health supplied special tabulations of Oklahoma deaths in 1949 and 1951 by place of usual residence for the rural and urban populations. The National Office of Vital Statistics supplied special tabulations of deaths for the year 1950. Deaths were classified by residence, according to the size of the city in the 1950 census enumerations using the "old urban" definition. In the construction of life tables, it is customary to average the deaths for the three years in order to minimize fluctuations in mortality rates among age groups.

It was necessary to estimate the population for each of the eight sex-race-residence groups as of July 1, 1950, the midpoint of the three years 1949, 1950, and 1951. This was done by obtaining the population for each of the age categories in Oklahoma on April 1, 1940 and comparing with the number of people of this group remaining in the State on April 1, 1950. Then, the average rate of change per quarter during the decade was computed after subtracting the 1940 population from the 1950 population and by dividing by 40. Each of these values was subtracted (or added) to the proper April 1, 1950 population group. For ages under 10, the population estimates were based on the census figures changed by the number of births and deaths in the three-month period ending July 1, 1950 plus corrections for underenumeration of children under five in the 1950 census.[8]

*The authors are grateful to Mrs. Lorene McEwen who did the computational work for this study.

REFERENCES

1. Metropolitan Life Insurance Company, *Statistical Bulletin*, Vol. 34, No. 7, July, 1953, p. 2.

2. *Ibid.*, p. 3.

3. Frank G. Dickinson and Everett L. Welker, *Mortality Trends in the United States, 1900-1949* (Chicago: American Medical Association, 1952), p. 3.

4. Warren S. Thompson, *Population Problems*, Third Edition (New York: McGraw-Hill Book Company, Inc., 1942), p. 245.

5. Metropolitan Life Insurance Company, *op. cit.*, p. 3.

6. *Ibid.*, p. 3.

7. Lowell J. Reed and Margaret Merrell, "A Short Method for Constructing an Abridged Life Table," *American Journal of Hygiene*, Vol. 30, No. 2, September, 1939, pp. 683-712.

8. *Current Population Reports, Population Estimates*, "Estimates of the Civilian Population of States, By Broad Age Groups July 1, 1953," Series P-25, No. 106, December, 1954, p. 13.

Appointed Chairman

Dr. Joseph M. White, Jr. has been appointed fulltime Chairman of the Department of Anesthesiology at the University of Oklahoma School of Medicine effective December 15. Dr. White has been on the faculty of the University of Washington School of Medicine since June, 1954.

A native of Dallas, Tex., Dr. White received his B.S. from Southern Methodist University and his M.D. from Southwestern Medical College, Dallas.

Receives Grant

The University of Oklahoma School of Medicine has received a two-year grant (totaling $25,148) from the National Institute of Health to study the relationship between stressful life experiences and fat-changes in the blood. The work will be conducted by Dr. Stewart Wolf, Head of the Department of Medicine, and Dr. James F. Hammarsten, Associate Professor of Medicine.

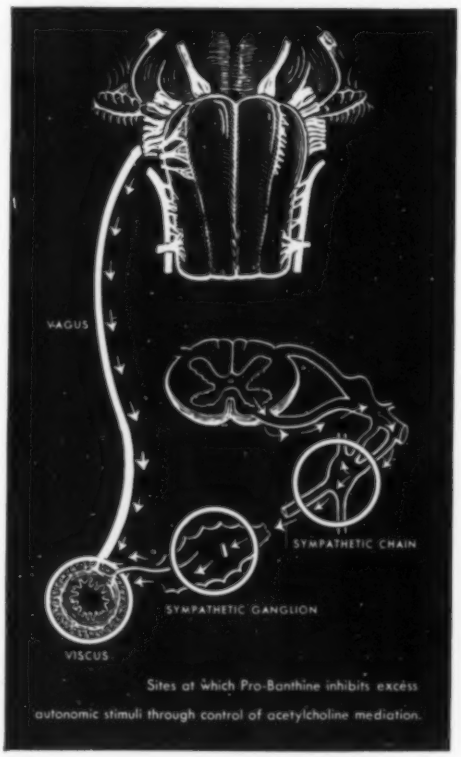
PRO-BANTHINE® FOR ANTICHOLINERGIC ACTION

A Combined Neuro-Effector and Ganglion Inhibitor

Pro-Banthine consistently controls gastrointestinal hypermotility and spasm and the attendant symptoms.

Pro-Banthine is an improved anticholinergic compound. Its unique pharmacologic properties are a decided advance in the control of the most common symptoms of smooth muscle spasm in all segments of the gastrointestinal tract.

By controlling excess motility of the gastrointestinal tract, Pro-Banthine has found wide use[1] in the treatment of peptic ulcer, functional diarrheas, regional enteritis and ulcerative colitis. It is also valuable in the treatment of pylorospasm and spasm of the sphincter of Oddi.



Sites at which Pro-Banthine inhibits excess autonomic stimuli through control of acetylcholine mediation.

Roback and Beal[2] found that Pro-Banthine orally was an "inhibitor of spontaneous and histamine-stimulated gastric secretion" which "resulted in marked and prolonged inhibition of the motility of the stomach, jejunum, and colon. . . ."

Therapy with Pro-Banthine is remarkably free from reactions associated with parasympathetic inhibition. Dryness of the mouth and blurred vision are much less common with Pro-Banthine than with other potent anticholinergic agents.

In Roback and Beal's[2] series "Side effects were almost entirely absent in single doses of 30 or 40 mg. . . ."

Pro-Banthine (β-diisopropylaminoethyl xanthene-9-carboxylate methobromide, brand of propantheline bromide) is available in three dosage forms: sugar-coated tablets of 15 mg.; sugar-coated tablets of 15 mg. of Pro-Banthine with 15 mg. of phenobarbital, for use when anxiety and tension are complicating factors; ampuls of 30 mg., for more rapid effects and in instances when oral medication is impractical or impossible.

For the average patient one tablet of Pro-Banthine (15 mg.) with each meal and two tablets (30 mg.) at bedtime will be adequate. G. D. Searle & Co., Research in the Service of Medicine.

---

1. Schwartz I. R.; Lehman, E.; Ostrove, R., and Seibel, J. M.: Gastroenterology *25*:416 (Nov.) 1953.
2. Roback, R. A., and Beal, J. M.: Gastroenterology *25*:24 (Sept.) 1953.

Clinical trial packages of Pro-Banthine and the new booklet, "Case Histories of Anticholinergic Action," are available on request to . . .

SEARLE

P. O. Box 5110-8-24
Chicago 80, Illinois

Association Activities

HAVE YOU HEARD?

WILEY T. MCCOLLUM, M.D., Oklahoma City, received notice on December 7, 1955, from the American Board of Internal Medicine that he has been certified in the sub-specialty of Cardiovascular Disease. Doctor McCollum is likewise a member of the American Board of Internal Medicine.

THE LESLIE-MCCAULEY CLINIC of Okmulgee is opening a branch office in Morris on Tuesday and Thursday afternoons. CLEVE BELLER, M.D. will be in charge of the office.

TURNER BYNUM, M.D., Oklahoma City, is studying the effect of Donnatal in functional colonic disease in his private practice under a grant from A. H. Robins Co., Inc.

J. N. MITCHELL, M.D., has assumed his duties as chief of staff of Memorial Hospital in Lawton.

W. F. BOHLMAN, M.D., formerly of Watonga, has moved his practice to Tulsa.

BURL E. STONE, M.D., formerly of Anadarko, has established his practice in Lawton.

Omer C. Coppedge, M.D., Bristow, (left) receives his 50 Year Pin from Past President Ralph McGill, M.D. Doctor Coppedge began practicing the summer of 1905 in Bristow and is still practicing there.

Ralph McGill, M.D., O.S.M.A. Past President, (right) presents Emory W. King, M.D., Bristow, with a 50 Year Pin. Doctor King, who started practicing in Bristow in December, 1905, reports he is still "going strong."

FRANK NELSON, M.D., Tulsa, discussed the history of medicine at a meeting of the Tulsa Green T Club recently.

H. R. BENDER, M.D., graduate of the University of Oklahoma School of Medicine who has been practicing in Wichita Falls, Texas, has opened his office in Lawton.

H. A. SCOTT, M.D., is the new president of the medical staff of Oklahoma Baptist Hospital, Muskogee.

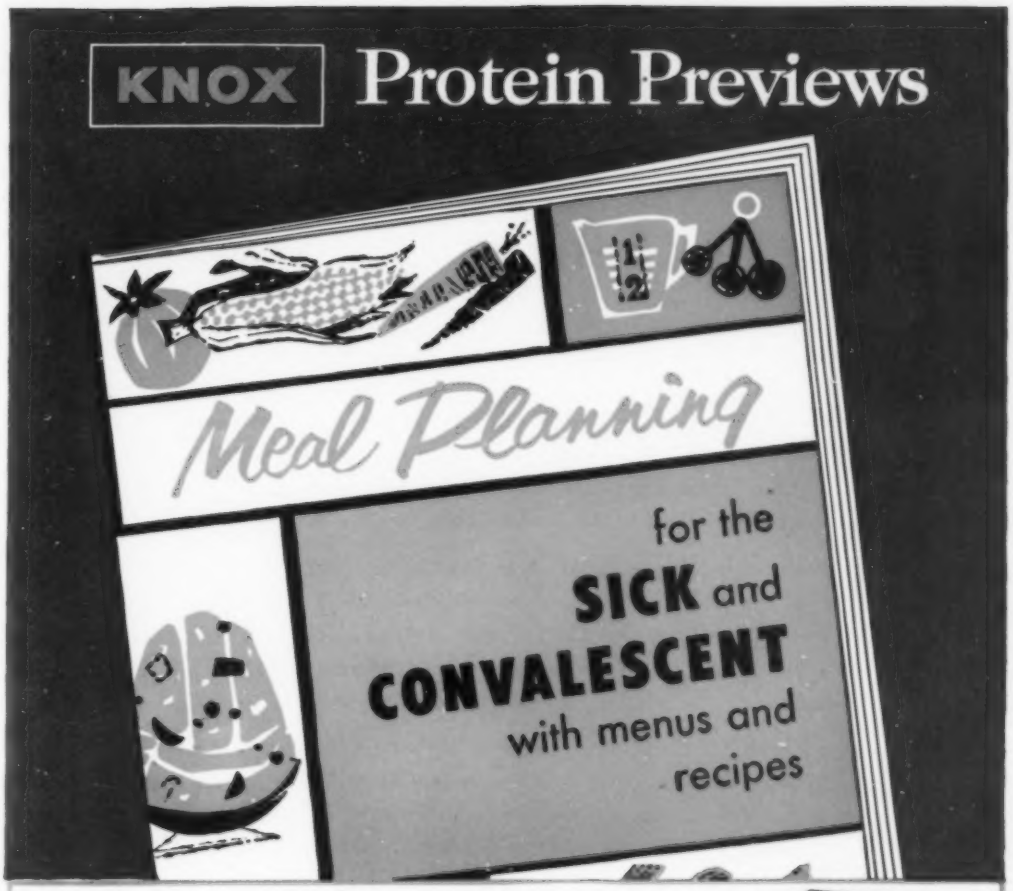
W. F. LEWIS, M.D., Lawton, is the newly elected president of the Lawton Council of Camp Fire Girls, Inc.

ROY W. ANDERSON, M.D., Cordell, is spending three months in postgraduate study at the University of Vienna, Austria.

MALCOM E. PHELPS, M.D., El Reno, presented a paper at the Southern Medical Association meeting in Houston in November on sodium pentothal as an anesthetic.

RALPH E. MEINHARDT, M.D., 1951 graduate of the University of Oklahoma School of Medicine, has opened his office in Yale.

KNOX Protein Previews



New Booklet Presents Latest Facts on Feeding the Sick

Adequate nutrition during illness and convalescence is essential for recovery whether the patient is managed in the hospital or at home. In the latter case, physicians often must devote much time to instructing those responsible for caring for the sick in good nutritional practices.

"Meal Planning for the Sick and Convalescent" has been designed to relieve you of the need for repeating over and over again essential dietary facts. This new Knox booklet presents in layman's language the latest nutritional applications ot proteins, vitamins and minerals, gives practical hints on serving food to adults and children, suggests ways to stimulate appetite and describes diets from clear liquid to full convalescent. Best of all it offers the homemaker for the first time detailed daily suggested menus for each type of diet, plus 14 pages of tested nourishing recipes.

If you would like copies of this new timesaving Knox booklet for your practice, use the coupon below.

Chas. B. Knox Gelatine Company, Inc.
Professional Service Department SJ-13
Johnstown, N. Y.

Please send me.....copies of the new Knox "Sick and Convalescent" booklet.

YOUR NAME AND ADDRESS

PRESIDENT'S LETTER

Perhaps many of you are wondering what has resulted from the action of the House of Delegates in Tulsa, May, 1955, when the House voted unanimously to build an office for headquarters of the Oklahoma State Medical Association. To finance this building, a special assessment of thirty-five dollars was voted by the House.

There have been many delays in securing and zoning a building site. Both problems have been solved. The building site has been selected. It is located on the Northwest By-pass where Shartel Street crosses the by-pass, about a block west of the Santa Fe railroad underpass. The zoning, much delayed for one cause or another, has been accomplished only recently.

The Building Committee has met on several occasions for deciding such problems as selecting an architect, studying styles of architecture appropriate for such an edifice, the floor plans and many other items incident to such an important structure. The plans you see in this issue of the *Journal* are the ones favored by the Committee. The Committee has done a time consuming job and hopes that every doctor in the state will be pleased with its results and the finished product.

Of course, to accomplish the final product, there is a little matter of financing that is conventionally accepted as a matter of course but building-wise, a necessity for progress. Speaking of assessment, allow me to congratulate the membership of two counties—Washington and Nowata (33 members) for having paid 100 per cent of the assessment. This is most commendable, and thanks to the members of Washington-Nowata Counties.

By the time the next *Journal* is published, we should be very glad to report your individual counties in the list with Washington-Nowata Counties. Rapid progress can be made if you take care of this now.

R. Q. Goodwin

President

NOW IN TWO POTENCIES

for more precise dosage

NEW 1 mg. *pink* tablet | 5 mg. tablet

MOST POTENT ANTI-RHEUMATIC

Sterane*

Both tablets are deep-scored and of the **SAME DISTINCTIVE "FINGER-GRIP" SIZE AND SHAPE** for ease of handling and breaking by arthritic fingers.

anti-rheumatic/anti-allergic/anti-inflammatory

supplied: **Pink,** 1 mg. oral tablets, bottles of 100.
White, 5 mg. oral tablets, bottles of 20 and 100.

PFIZER LABORATORIES
Division, Chas. Pfizer & Co., Inc.
Brooklyn 6, New York

*brand of prednisolone

Academy of General Practice Issues Invitation To Meeting

All members of the Oklahoma State Medical Association are invited to attend the annual meeting of the Oklahoma Academy of General Practice to be held February 6-7, 1956 at the Tulsa Hotel in Tulsa. There is no registration fee.

Six outstanding guest speakers have been secured for the program. They are: E. L. Compere, M.D. (orthopedics); Edward H. Hashinger, M.D. (internal medicine); James L. Dennis, M.D. (pediatrics); L. H. McDaniels, M.D., (general practice); Newton D. Smith, M.D. (proctology); and Wm. F. Guerriero, M.D. (obstetrics-gynecology). Doctor McDaniels will also be the after dinner speaker at the annual dinner which will be held Monday night, February 6.

A complimentary breakfast will be held Tuesday morning, February 7 for the phvsicians and their wives. A luncheon and style show is also planned for the wives of the doctors who attend the meeting.

Earl M. Lusk, M.D., Tulsa, is president of the Oklahoma Academy of General Practice and Mark Holcomb, M.D., Enid, is President-Elect and will take office at the inaugural dinner during the meeting. V. M. Rutherford, M.D., Midwest City, is secretary-treasurer.

ANNOUNCEMENTS

Oklahoma Academy of General Practice

February 6-7, 1956, Tulsa Hotel, Tulsa, Oklahoma.

University of Colorado School of Medicine

General Practice Review. January 16-21, 1956. Denver, Colo.

Hawaii Medical Association

Centennial April 22-29, 1956, following the American College of Physician's session in Los Angeles. For further information, write the Hawaii Medical Association, 510 South Beretania St., Honolulu 13, Hawaii.

American Academy of General Practice

Eighth scientific assembly March 19-22, 1956, Washington, D. C.

Institute in Psychiatry and Neurology

Veterans Administration Hospital, North Little Rock, Ark. March 1 and 2, 1956.

American Academy of Allergy

Twelfth annual meeting, February 6-8, 1956, Chase Hotel, St. Louis, Mo.

American College of Radiology

February 10, 1956, Drake Hotel, Chicago, Ill.

Oklahoma State Medical Association

Annual Meeting, May 6-7-8-9, 1956, Municipal Auditorium, Oklahoma City, Okla.

Bondurant Named Chairman of Public Welfare Group

Charles P. Bondurant, M.D., Oklahoma City, has been elected a member of the Board of Directors and Chairman of the National Council of State and Local Board Members of the American Public Welfare Association.

The Association, composed of representatives of 53 states and territories, held the election at its biennial round table conference held in Washington, D. C. November 30-December 3.

Doctor Bondurant succeeds Dr. Harry E. Robbins, Denver, Colo. as chairman. The Council of which Doctor Bondurant is chairman is a very important part of the policy making group which studies and recommends needed legislation on welfare problems, service and standards to the National and State Governments. He has been chairman of the Oklahoma Public Welfare Commission since his appointment to the Commission on November 5, 1951.

Doctor Bondurant, an Oklahoma City dermatologist, was graduated from the University of Oklahoma School of Medicine in 1924. He interned at Indianapolis City Hospital and served a residency at New York Skin and Cancer Hospital. He was certified by the American Board of Dermatology and Syphilology in 1938. Professor of Dermatology at the University of Oklahoma School of Medicine, he is a member of the American Academy of Dermatology and Syphilology and the American College of Physicians.

Upjohn

Rheumatoid arthritis, rheumatic fever, intractable asthma, allergies . . .

Cortef* *tablets*

Supplied:

5 mg. tablets in bottles of 50
10 mg. tablets in bottles of 25, 100, 500
20 mg. tablets in bottles of 25, 100, 500

*REGISTERED TRADEMARK FOR THE UPJOHN BRAND OF HYDROCORTISONE (COMPOUND F)

The Upjohn Company, Kalamazoo, Michigan

PHOTO DATA. CAMERA: 4X5 REFLEX; EXPOSURE: 1/200 SEC. AT F.8 EXISTING LIGHTING.

ACHROMYCIN*

Hydrochloride
Tetracycline HCl *Lederle*

widely pre
1) rapid c
2) prompt
3) negligi
4) true b
against
Gram-p
ettsiae,
5) every g
tories u
only und
6) a *compl*

LEDERLE

*REG. U. S. PAT. OF

widely prescribed because of these important advantages:

1) rapid diffusion and penetration
2) prompt control of infection
3) negligible side effects
4) true broad-spectrum activity (proved effective against a wide variety of infections caused by Gram-positive and Gram-negative bacteria, rickettsiae, and certain viruses and protozoa)
5) every gram produced in Lederle's *own* laboratories under rigid quality control, and offered *only* under the Lederle label
6) a *complete* line of dosage forms

LEDERLE LABORATORIES DIVISION *American Cyanamid Company* PEARL RIVER, NEW YORK

Lederle

*REG. U. S. PAT. OFF.

Deaths

Felix M. Adams, M.D.
1884-1955

Felix M. Adams, M.D., medical superintendent of Eastern State Hospital at Vinita since it opened in January, 1913, died December 3. He had been ill with a heart ailment for two months.

Doctor Adams, the oldest mental hospital superintendent in the nation in point of continuous service, was inducted into the Oklahoma Hall of Fame in 1954.

Doctor Adams was born January 30, 1884 in Celeste, Texas. He attended Baylor University and received his medical degree from Barnes School of Medicine, St. Louis.

He was a member of the official board of the First Methodist Church, a 32nd degree Mason and a member of the Akdar Shrine, past president of the Vinita Rotary Club, treasurer and director of the Phoenix Federal Savings and Loan Association and a member of the Vinita Chamber of Commerce.

He was secretary of the Ottawa-Craig County Medical Society, the American Psychiatric Association, Southern Medical, Oklahoma and Southwestern Neurological Associations.

Survivors include the widow of the home address, two sons, Felix Adams, Jr., M.D. and John Adams, and a daughter, Mrs. Phil Salkeld, wife of a Quanah, Texas, physician. Three brothers, four sisters and five grandchildren also survive.

Henry A. Howell, M.D.
1874-1955

Henry A. Howell, M.D., pioneer Holdenville physician died at Veterans Hospital at Sulphur November 25.

Doctor Howell was born July 8, 1874 at Dover, Ark. and graduated from Emory University, Atlanta, Georgia. He retired from active practice about a year ago. He served in the medical corps in World War I. Doctor Howell was a member of the Methodist Church, the Masonic Lodge and the American Legion. He was a member of the Rotary Club for many years.

Samuel B. Leslie, M.D.
1874-1955

Samuel B. Leslie, M.D., Okmulgee, died November 11, 1955, from a coronary occlusion.

Doctor Leslie was born April 6, 1874, at Leslie, Arkansas. As a young man he taught school in Arkansas and later rode horseback throughout this part of old Indian Territory selling fruit trees. He attended Denver Medical College, graduating in 1902. He worked his way through medical school delivering newspapers. In 1902 he came to Okmulgee, Oklahoma, where he practiced medicine until his death, a period of 53 years.

Doctor Leslie was very active in civic and medical work. He was a member and president of the Okmulgee Board of Education from 1910 to 1931. He served on the Board of Stewards and the Board of Trustees of the First Methodist Church in Okmulgee for many years. He also served as a teacher and superintendent in the Sunday School. He was a Mason.

Doctor Leslie was a charter member of the Okmulgee County Medical Society and served several times as president. He served on the Oklahoma Board of Medical Examiners for eight years and was a Life Member of the Oklahoma State Medical Association. In 1952 he received a 50 Year Pin.

His wife survives and one son, Samuel B. Leslie, Jr., M.D., three daughters, Mrs. Harold Hunsaker, Mrs. Glenn Echoles and Mrs. Bishop Shields.

Albert Cicero Peacock, M. D.
1867-1955

Albert Cicero Peacock, M.D., retired pioneer physician, died at a Tulsa convalescent home November 28 after a 10 month illness.

Doctor Peacock, who was 88, practiced in Tulsa from 1908 until he retired in 1934. He was born in Lexington, N. C. and was graduated from Sewanee of the South school of medicine.

RAPIDLY EFFECTIVE
BROAD-SPECTRUM ANTIBIOTIC THERAPY
...WELL TOLERATED...
BY THE INTRAMUSCULAR ROUTE
TERRAMYCIN®
Brand of oxytetracycline
INTRAMUSCULAR
"IN CHILDREN, GASTROENTERITIS, CROUP, MENINGITIS, AND INFECTIONS COMPLICATING CERTAIN SURGICAL CONDITIONS MAY BE ADEQUATELY TREATED BY ITS USE AND IT IS ...[A] DRUG OF CHOICE WHEN ORAL MEDICATION IS NOT POSSIBLE."*
*Schneider, F. H.: Ohio State M. J. 51:347 (April) 1955.
TERRAMYCIN INTRAMUSCULAR
Single-dose vials providing 100 mg. crystalline oxytetracycline hydrochloride, 5 per cent magnesium chloride and 2 per cent procaine hydrochloride.
Pfizer
PFIZER LABORATORIES, Division, Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y.

PHYSICIAN PLACEMENT

The following physicians have expressed a desire to locate in Oklahoma. To the best of our knowledge, the names, addresses, qualifications and availability are current and accurate.

The asterisk beside some names indicates that additional information concerning the physician is available in this office.

Dermatology

Leonard D. Grayson, 1301 Cornaga Ave., Far Rockaway 91, N.Y. Age 34, medical school unknown (Grade A), Board Eligible in Dermatology, available immediately.

General Practice

*Ake Akerberg, Multragatan 20, Stockholm, NGBY, Sweden, age 38, University of Helsinki, Finland, available January, 1956.

*Charles Dail Davenport, 814 N. Elm, Hoisington, Kansas, age 30, University of Oklahoma School of Medicine, 1953, veteran, available July, 1956.

*John V. Hume, 931 W. 15, Pueblo, Colo., age 31, University of Colorado 1953, residency in general practice, veteran, availability unknown.

Elmer D. Peffly, Capt., USAF (MC), Aviation Medical Examiner, 3545th USAF Hospital, Office of the Flight Surgeon, Goodfellow Air Force Base, Texas, age unknown, University of Oklahoma School of Medicine, 1953, interned at Wesley Hospital, Oklahoma City, available June, 1956.

*Harvey Lewis Paul Resnik, Philadelphia, Pa., Philadelphia General Hospital, age 25, College of Physicians and Surgeons, Columbia University, 1955, available July 1, 1956.

Internal Medicine

*Marvin J. Colbert, Apt. 110, 809 S. Marshfield Ave., Chicago 12, Ill., age 31, University of Boston 1949, two and one-half years residency in internal medicine, veteran, available August 1, 1955.

*Robert Henry Frankenfeld, U. S. Naval Hospital, Quantico, Va., age 31, Cornell University 1947, Board eligible in Internal Medicine, active military duty, available October 1, 1955.

*William Prothro Jolly, 803 Fifth St., Rural Route No. 1, Iowa City, Iowa, age 32, University of Michigan, 1949, residency in internal medicine, veteran, available July 1, 1956.

*C. A. Loughridge, 1107 E. Upsal St., Philadelphia 19, Pa., age 36, College of Physicians and Surgeons Columbia University 1954, in internal medicine residency at Philadelphia General Hospital, available between July and September, 1956.

*Alfred M. Steinman, 515 Ocean Ave., Brooklyn 26, N. Y., age 32, Long Island College of Medicine 1949, residency in Internal Medicine and Cardiology, veteran, available immediately.

Orthopedics

*Andrew G. Hudacek, Kosair Crippled Children Hospital, Louisville 17, Kentucky, age 31, Georgetown University 1948, Board eligible in Orthopedics, veteran, available October 1, 1955.

Robert E. Landstra, American Legion Hospital for Crippled Children, 2350 Lakeview Ave., St. Petersburg, Florida, age unknown, now in orthopedic residency training, availability unknown.

Pathology

*James Kendall Boyd, 1745 S. St. Louis Ave., Tulsa, Okla., age 39, University of Tennessee 1942, Board eligible in Pathology, veteran, available immediately.

*William McIntosh Hindman, Receiving Hospital, Detroit, Michigan, age 38, University of Tennessee, 1945, four year pathology residency, Detroit Receiving Hospital, Board eligible, available July, 1956.

Pediatrics

*Arthur T. Hall, 314 Allison St., Sayre, Pa., age 33, University of Rochester 1952, two year residency in Pediatrics, veteran, available July 1, 1955.

*Leslie W. Langley, Jr., 1709 De Pauw Ave., New Albany, Ind., age 32, University of Louisville School of Medicine, 1953, now taking second year of pediatric residency, veteran, available July 1, 1956.

*Ralph Lee Perry, 10812 Mt. Carmel Rd., Cleveland 4, Ohio, age 32, Western Reserve University, 1953, two years, appr. pediatric training, veteran, available July 1, 1956.

Surgery

Alice F. Gambill, 1605 Clover Lane, Fort Worth, Texas, University of Oklahoma 1949, one year residency in General Surgery, available immediately.

*William A. Holbrook, Jr., University Hospital, Baltimore, Maryland, age 34, University of Maryland 1945, Board qualified in General Surgery, veteran, available August, 1955.

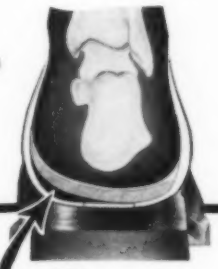
*C. Richard Jernigan, Parkland Memorial Hospital, Dallas, Texas, age 29, Southwestern Medical College 1948, will be Board qualified in General Surgery January 1, 1956, veteran, available January 1, 1956.

Urology

Woodrow Payne, M.D., 764 McConnell, Memphis, Tenn., age 34, University of Tennessee, 1944. Board Qualified in Urology, veteran, available July, 1956. (Wants city 20,000-75,000 — private proup, partnership).

*David M. Stahl, 2624 W. 75th Pl., Kansas City 13, Missouri, age 28. Baylor College of Medicine 1952, in residency in urology, veteran, available July 1, 1956.

Foot-so-Port Shoe Construction and its Relation to Weight Distribution



- Insole extension and wedge at inner corner of heel where support is most needed.
- Special Supreme rubber heels are longer than most anatomic heels and maintain the appearance of normal shoes.
- The patented arch support construction is guaranteed not to break down.
- Innersoles are guaranteed not to crack, curl, or collapse. Insulated by a special layer of Texon which also cushions firmly and uniformly.
- Foot-so-Port lasts were designed and the shoe construction engineered with orthopedic advice.

Now Available! Men's conductive shoes. N.B.F.U. specifications. For surgeons and operating room personnel.

- By a special process, using plastic positive casts of feet, we make more custom shoes for polio, club feet and all types of abnormal feet than any other manufacturer.

Write for details or contact your local **FOOT-SO-PORT** *Shoe Agency. Refer to your Classified Directory*

Foot-so-Port Shoe Company, Oconomowoc, Wis.

WE CORDIALLY INVITE YOUR INQUIRY for application for membership which affords protection against loss of income from accident and sickness (accidental death, too) as well as benefits for hospital expenses for you and all your eligible dependents.

SINCE 1902

ALL PREMIUMS COME FROM PHYSICIANS SURGEONS DENTISTS

ALL BENEFITS GO TO

$4,500,000 ASSETS
$22,500,000 PAID FOR BENEFITS

PHYSICIANS CASUALTY AND HEALTH ASSOCIATIONS
OMAHA 2, NEBRASKA

Report on Actions of the House of Delegates, American Medical Association 9th Clinical Meeting

Social security, the report of the Committee on Medical Practices, grievance committees and revisions of the code of medical ethics were among the major subjects of discussion and action by the House of Delegates at the American Medical Association's Ninth Clinical Meeting held Nov. 29-Dec. 2 in Boston.

Named as the 1955 General Practitioner of the Year was Dr. E. Roger Samuel of Mount Carmel, Pa., whose selection by a special committee of the Board of Trustees was announced at the opening session on Tuesday. Doctor Samuel, a former member of the House of Delegates and a general practitioner for 35 years, received the medal and citation presented annually for community service by a family doctor.

Total registration at the end of the third day of the meeting had reached 7,027, including 3,672 physicians.

Social Security

Major legislative policy action taken at the Boston meeting involved H.R. 7225, known as the Social Security Amendments of 1955. This bill, which was passed last summer by the U.S. House of Representatives and is now pending before the Senate Finance Committee, includes a proposal for federal cash benefits to selected individuals judged to be permanently and totally disabled. The House of Delegates adopted a substitute resolution proposed by the Reference Committee on Legislation and Public Relations to combine the intent of four resolutions and three supplementary reports of the Board of Trustees dealing with H.R. 7225 and other aspects of Social Security. The substitute resolution stated the following policy:

"That the American Medical Association reiterate in the strongest possible terms its determination to resist any encroachment upon the American system of medical practice which would be detrimental to our patients, the American people;

"That the American Medical Association urge and support the creation of a well-qualified commission, either governmental or private or both, to make a thorough, objective and impartial study of the economic, social and political impact of Social Security, both medical and otherwise, and that the facts developed by such a study should be the sole basis for objective non-political improvements to the Social Security Act, for the benefit of all of the American people;

"That the American Medical Association pledges its wholehearted cooperation in such a study of Social Security in the United States, and will devote its best efforts to procuring and providing full information on the medical aspects of disability, rehabilitation and medical care of the disabled, and

"That copies of this resolution be transmitted to the President of the United States, to all members of the Cabinet, to all members of the Congress, and to all constituent state medical associations."

Report on Medical Practices

The House passed a substitute resolution offered by the Reference Committee on Insurance and Medical Service to implement the findings and recommendations of the Committee on Medical Practices (Truman Committee), which studied the basic causes leading to certain unethical practices and unfavorable publicity.

The House also approved a supplementary report of the Board of Trustees which included the following suggestions:

1. All non-surgical groups should be asked for their suggestions and cooperation in carrying out a public education program on the value of diagnostic and medical work.
2. The various specialty boards should be encouraged to reappraise the practice restrictions on their board diplomates.
3. The American Medical Association should continue to discourage arbitrary restrictions by hospitals against general practitioners.
4. Organized medicine is "ready, willing and able to solve satisfactorily its own problems, and such assurance should be given to the American Hospital Association or any other group concerning itself with such problems."

THE OKLAHOMA STATE MEDICAL ASSOCIATION INSURANCE TRUST offers each physician, under age 65, group life, accidental death, dismemberment and loss of sight insurance. This valuable program is available at low group rates as shown in the following example:

Age	*Life Insurance*	*Annual Cost*	*Accidental Death Insurance*	*Annual Cost*	*Total Annual Cost*
30	$10,000	$ 38.60	$10,000	$12	$ 50.60
40	10,000	67.00	10,000	12	79.00
50	10,000	133.50	10,000	12	145.50
60	7,500	216.15	7,500	9	225.15

A letter announcing the availability of this program has been mailed to each physician. The group life rates were included in the letter but inadvertently the accidental death rates were not included. This additional coverage cost is only $12 annually up to age 60 or $9 annually from age 60 thru age 64.

Additional details of this program are available from the offices of your State Association or the Trust at 1240 First National Building, Oklahoma City. You are urged to apply before February 15.

MASSACHUSETTS MUTUAL
LIFE INSURANCE COMPANY

Guides for Grievance Committees

The House approved the report of the Committee to Recommend Guides for Grievance or Mediation Committees and commended the committee for "their superb approach to this problem." Purpose of the guides is "to promote general uniformity of organization and function of grievance committees—and better understanding of their purposes—without interfering with the inherent autonomy of constituent medical associations. Constituent associations are therefore urged to implement these guides without delay."

Medical Ethics

A proposed revision of the "Principles of Medical Ethics and Precepts of Manners of the American Medical Association" was submitted to the House by the Council on Constitution and Bylaws. The following reference committee suggestion was adopted by the House:

"In discussion it became evident that there was need for wide distribution of these principles and careful study of the proposed changes not only by this Reference Committee but also by all members of the House and in fact all members of the Association. It seemed desirable also that the two Councils (Council on Constitution and Bylaws and the Judicial Council) should meet in joint session to consider these proposals. Your Reference Committee therefore recommends that these proposals be tabled for further consideration at the next annual session of the House to be held in Chicago in June, 1956.

"In the meantime, it is recommended that these proposals in their entirety be widely publicized and that consideration be given to publishing, in the *Journal* of the American Medical Association and also in state medical journals, these proposed changes in the Principles. It is also recommended that consideration be given to the mailing of copies to each member of the Association. Finally, your Reference Committee recommends that prior to the meeting in Chicago next June the Council on Constitution and Bylaws and the Judicial Council meet in joint session to consider these proposed changes."

In another action on revisions of medical ethics, the House also approved a plan requiring that all resolutions dealing with changes in the Principles of Medical Ethics shall be considered over a period between sessions of the House before final adoption.

Miscellaneous Actions

Among many other actions on a variety of other subjects, the House of Delegates also:

Recommended that the Board of Trustees give consideration to a dues increase for all Association members, with the increase designated for contribution to the American Medical Education Foundation;

Adopted a resolution on the practice of pathology declaring opposition to "the division of any branch of medical practice into so-called technical and professional services";

Recommended that further purchase and distribution of Salk polio vaccine be carried on by the presently available commercial avenues used for other immunizing agents, and that all vaccines, once proven, should enter the usual channels of distribution;

Approved appointment of an A.M.A. committee to study the prevention of highway accidents;

Commended the Women's Auxiliary of the A.M.A. for its financial contributions in support of medical education and requested the Auxiliary to continue its active efforts;

Commended the Sears Roebuck Foundation for its thoughtfulness and foresight in sponsoring the new plan for financial assistance in establishing medical practice units;

Received progress reports from the Commission on Medical Care Plans and from the A.M.A. Law Department on its studies of professional liability;

Approved a Board of Trustees recommendation that the State Journal Advertising Bureau be separated from the American Medical Association and be given full autonomy;

Congratulated the physicians of Iowa for their efforts in supporting the position that the practice of medicine is the right of the individual, and

Approved the selection of Minneapolis for the 1958 Clinical Meeting and Chicago for the 1960 Annual Meeting.